Name of Patient: _____ **Date:** _____

Chief Complaint/s: _____

Is today's visit related to a MVC (motor vehicle collision) or a Work Comp claim? _____

MEDICATIONS

List all current prescription, non-prescription medications, vitamins, and herbal products. Please INCLUDE even occasional use of aspirin or anti-inflammatory medication (ex: Motrin, Naproxen).

Name of Medication	**Strength**	**Frequency Taken**

Do you take Aspirin/Acetaminophen? _____

PATIENT'S MEDICAL HISTORY Check those that are applicable: (active or inactive)

-Gastro-
- □ Gallstones
- □ Pancreatitis
- □ Peptic Ulcer Disease
- □ Hepatitis
- □ Irritable Bowel Syndrome
- □ Reflux, GERD

-Cancer-
- □ Breast
- □ Skin
- □ Prostate
- □ Colon
- □ Lung
- □ Other: _____

-Heart/Lung-
- □ Angina
- □ Heart Attack
- □ Congestive Heart Failure
- □ Mitral Valve Prolapse
- □ Heart Valve Disease
- □ Atrial Fibrillation
- □ High Blood Pressure
- □ High Cholesterol
- □ Stroke
- □ COPD; Emphysema
- □ Asthma
- □ Sleep Apnea

-Neuro
- □ Headaches
- □ Seizures
- □ Neuropathy
- □ Epilepsy

-Metab/Other
- □ Rheumatoid Arthritis
- □ Fibromyalgia
- □ Kidney Stones
- □ Chronic Renal Failure
- □ Diabetes Mellitus
- □ Osteoporosis/DJD
- □ Glaucoma
- □ Depression
- □ Bipolar Disorder

Other medical history not listed above: _____

_____

Do you have any implantable devices? □ NO □ YES, type: _____

Please supply the front desk with a copy of your card.

ALLERGIES □ NONE

Other Allergies: INCLUDE allergies to medications, medical products, etc. Please include reaction to allergen. (ex: gabapentin: stomach upset, latex: hives)

Name of Medication/Product	Description of reaction

HOSPITALIZATION (Inpatient) □ NONE □ YES (list Hospital, reason & year below)

Hospital Name	**Reason**	**Year**

SURGICAL HISTORY (Inpatient or Outpatient) □ NONE □ YES (list Type and reason below)

Hospital/Clinic Name	**Reason**	**Year**

FAMILY MEDICAL HISTORY

Mother	Age	Medical History	Child □ M □ F	Age	Medical History
Father	Age	Medical History	Child □ M □ F	Age	Medical History
Sibling □ M □ F	Age	Medical History	Child □ M □ F	Age	Medical History
Sibling □ M □ F	Age	Medical History	Child □ M □ F	Age	Medical History

Other family history not listed above:

HEALTH HABITS AND HOME STATUS

ALCOHOL USE (In the past year)

Did you have a drink containing alcohol in the past year? □ NO *(Skip to Tobacco/Vape Use)* □ YES

If yes, how often did you drink alcohol in the past year?
□ Monthly or less □ 2-4x a month □ 2-3x a week □ 4x or more per week

If yes, how many alcohol drinks on a typical day?
□ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more

If yes, how often did you have 6 or more drinks on 1 occasion?
□ Never □ Less than monthly □ Monthly □ Weekly □ Daily/almost daily

TOBACCO/VAPE USE

Are you a Tobacco user? □ Never a tobacco user *(Skip to Drug Use)* □ Former tobacco use

Are you a Vape user? □ Never a Vape user *(Skip to Drug Use)* □ Former vaper use

If former smoker/chew/vape, year started: _____ Year quit: _____ *(Skip to Drug Use)*

If current smoker/chew/vape, year started: _____ Do you use: □ every day □ some days

How soon upon waking do you smoke your first cigarette? □ within 5 min □ 6-30 min □ 31-60 min □ after 60 min

□ Cigarettes: _____/per day □ Vape: _____/per day

Are you interested in quitting? □ Ready to quit □ Thinking about it □ Not ready to quit

DRUG USE

Do you currently use recreational or street drugs? □ NO *(Skip to Caffeine Use)* □ YES

If yes, what type? _____ How often? _____

Have you ever used street drugs with a needle? □ NO *(Skip to Caffeine Use)* □ YES

CAFFEINE USE

Do you drink caffeine? □ NO *(Skip to Home Status)* □ YES, type: _____

HOME STATUS

Do others live at home with you? □ NO □ YES

Do you live in an Assisted Living Facility? □ NO □ YES, please list name of facility below

Name of facility: _____

Revised 12/22/2022 zm

Patient Name: _____ DOB: _____ Date: _____

REVIEW OF SYSTEMS – *Please circle any symptoms you have had in the last 30 days*

-Constitutional
loss of appetite
excessive appetite
fatigue
difficulty sleeping
lack of exercise
night sweats

-Endocrine
feeling hot or cold
excessive thirst
excessive sweating

-Allergic, Immunologic
frequent sneezing
seasonal allergies
increased infections

-Eyes-
Glaucoma
blurred vision
double vision
eye pain or itching
watery eyes
cataracts

-Ear,Nose,Throat-
loss of hearing
earache
ringing in ears
dizziness
dental problems
sore tongue
taste changes
swelling of gums
nasal congestion
sore throat
enlarged tonsils
hoarse voice

-Pulmonary, Respiratory
chronic cough
productive cough
hemoptysis
chronic bronchitis
sleep apnea
snoring
daytime sleepiness
unrefreshed sleep

-Cardiovascular
palpitations
angina
swelling of feet or ankles
SOB with exertion
sleeps on multiple pillows to breath
heart murmur requiring antibiotic

-Gastrointestinal
heartburn
difficulty swallowing
bloating
belching
nausea
frequent vomiting
vomiting blood
abdominal pain
constipation
diarrhea
black stools
pain in rectum
rectal bleeding
stool incontinence

-Urogenital, Genitourinary
nighttime frequency
blood in urine
urgency
difficulty starting to urinate
burning on urination
urinary incontinence
MEN
painful testicles
weak urine stream
prostate problems
lumps/masses on testicles
discharge from penis
WOMEN
menstrual problems
breakthrough bleeding
hot flashes
lumps/mass in breast

-Musculoskeletal
joint pain from arthritis
muscle aches
back pain
joint swelling
neck pain

-Dermatology, Integumentary
chronic skin condition
recent rash
excessive itching
acne
hives

-Neurological
dizziness
lightheadedness
vertigo
numbness
tremor
seizures
traumatic brain injury
headache(s)
migraine(s)
impaired speech
tingling feeling
radiating pain
shooting pain
burning pain
imbalance
difficulty walking

-Psychiatric
depression
difficulty making decisions
lack of concentration
memory loss
cries often
worries excessively
panic attacks
wanting psychiatric help

-Hematologic, Lymphatic
diagnosis of anemia
bleeding easily
bruising easily
swelling of lymph nodes
iron deficiency

Brain and Spine Center, PLC

Please complete in black/blue ink or typed

Name: _____
Last *First* *MI*

Date of Birth: _____ SSN#: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Gender: □ M □ F □ T: Preference_____ Marital Status: □ S □ M □ D □ W

Phone: Hm: _____ Cell: _____ Wk: _____

Primary preference: □ HM □ CELL □ WK Text Okay? □ YES □ NO

Permission to leave a detailed message on voicemail of home/cell phone: □ YES □ NO

Email: _____ Email okay? □ YES □ NO

Employer: _____ Occupation: _____

Race : □ Caucasian □ Asian □ Native American □ Other: _____

Primary Language: □ English □ Spanish □ Other: _____

PROVIDER INFORMATION

Primary Care Provider: _____ PCP's Phone #: _____

Did your PCP refer you to BSC? □ YES □ NO, please list referring provider below

Referring Provider: _____ Ref. Phone #: _____

POA/CAREGIVER/EMERGENCY CONTACT INFORMATION

Do you have a Power of Attorney or a Caregiver? □ NO □ YES, please list below

Name of POA/Caregiver: _____ POA/Caregiver's Phone #: _____

Name of Emerg. Contact: _____ Relation: _____

Emerg. Contact Phone: Hm: _____ Cell: _____

HIPAA Rights to Emerg. Contact? □ YES □ NO

HIPAA Rights to Others? □ NO □ YES, please list below

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Cross Roads: _____

Phone No.: _____Street Address: _____

MEDICATION HISTORY CONSENT

A medication history is a list of medications that Brain and Spine Center and other providers have prescribed for a patient. Information is collected from a variety of sources including, a patient's pharmacy, health plans, other healthcare providers, and the Arizona State Pharmacy Board.

I give my consent for Brain and Spine Center, PLC to retrieve and review my medication history. I understand that this will become part of my confidential medical record.

Patient Signature: _____ Date: _____

Medication Prior Authorizations: ***Brain and Spine Center works with CLOUD TOP HEALTH. They are a company that provides medication authorizations support to Providers Offices. If a medication was prescribed by one of our Providers and requires a prior authorization before dispensing, it will be sent to CLOUD TOP HEALTH. They will contact you to inform you of the status of the request and or if they have any questions. Once the medication is approved, cloud top will contact you and your pharmacy of the approval.***

PRIMARY INSURANCE **MUST BE COMPLETED BY PATIENT FOR INSURANCE BILLING PURPOSES**

Policy Holder: _____ Relationship to Policy Holder: □ SELF □ SPOUSE

Insurance Plan: _____ Subscriber Id: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

PolicyHolder's Date of Birth: _____ PolicyHolder's SSN#: _____

* * * * * * * *

SECONDARY INSURANCE **MUST BE COMPLETED BY PATIENT FOR INSURANCE BILLING PURPOSES**

Policy Holder: _____ Relationship to Policy Holder: □ SELF □ SPOUSE

Insurance Plan: _____ Subscriber Id: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

PolicyHolder's Date of Birth: _____ PolicyHolder's SSN#: _____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient Signature: _____ Date: _____

BRAIN AND SPINE CENTER
FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your neurology provider. We are committed to providing you with quality health care. Please read this payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

INSURANCE Brain and Spine Center contracts with many insurance companies. It is the patient's responsibility to verify with their plan that Brain and Spine Center is a participating provider. It is also the patient's responsibility to find out what coverage options and benefits are with your insurance plan. If you are not insured by a plan we are contracted with, or do not have insurance, we do offer a self-pay amount. This payment is due in full at each visit.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES All co-payments must be paid at the time of service. All remaining balances must be paid upon receipt of the statement/invoice. If a patient is subject to a deductible and/or co-insurance, there is a fixed amount that will be due at the time of the visit that will be applied towards any outstanding balance after the claim has processed.

REFERRALS, AUTHORIZATIONS There are insurances plans that require referrals and/or authorizations prior to a patient being seen for a visit and/or procedure. A scheduled appointment may be cancelled and/or rescheduled until such time that necessary referrals and/or authorizations are in place. Our office will attempt to obtain referrals and/or prior authorizations from your insurance company. This is not a guarantee that your insurance company will pay for the visit and/or procedure. Please contact your insurance company with any questions you may have regarding your coverage.

NON-COVERED SERVICES Please be aware that any service(s) considered to be a non-covered benefit by your insurance will be your financial responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

PROOF OF INSURANCE We do require a copy of your current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. A scheduled appointment may be cancelled and/or rescheduled until such time that necessary insurance information has been resolved.

CLAIMS SUBMISSION Brain and Spine Center will submit insurance claim forms along with the medical records necessary to obtain payment from your insurance company. The patient is responsible for all charges regardless of insurance coverage. We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request.

RETURNED CHECKS A $35.00 fee will be charged in the event of a returned check. In the event of this occurrence, we will no longer allow personal checks.

NON-PAYMENT Please be aware that if a balance remains unpaid after 90 days, we may refer your account to an outside collection agency, and a $35.00 processing fee will be assessed to the account. Once an account has been turned over to collections, patients are discharged from the practice, and are unable to receive further treatment from Brain and Spine Center.

MISSED (NO SHOW) AND SAME DAY APPOINTMENT POLICY Our office has a 24-hour cancellation policy for office visits, otherwise there will be a $50.00 fee billed directly to you. Our office also has a 48-hour cancellation policy for procedures, otherwise there will be a $200.00 fee billed directly to you. In the event that there are repeated no shows, or same day cancellations (in excess of 3), patients may be discharged from the practice and are unable to receive further treatment from Brain and Spine Center. Please help us to serve you better by keeping your regularly scheduled appointments.

FORMS There is a $50.00 fee for FMLA, Short-term disability and all other types of documents that require a provider to complete. The fee is due at the time of the visit. Brain and Spine Center does not complete Long-term disability paperwork.

EQUIPMENT Some procedures may require patients to take Brain and Spine equipment home with them. Patient's are financially responsible for any and all equipment damages which incur during any studies, or while the equipment is in the patient's care.

I have read and understand the payment policy and agree to abide by its guidelines.

Patient's Name (Print)_____ Date of Birth_____

Patient's Signature_____ Today's Date_____

Revised 12/22/2022 zm

Brain and Spine Center, PLC

Attestation of Receipt of Arizona's health information exchange (HIE) Practices:

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Brain and Spine Center, PLC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

Patient's Name (Print)_____Date of Birth_____

Patient's Signature_____Today's Date_____

FOR OFFICIAL USE ONLY

I, _____(BSC Employee), made a good faith effort to

obtain written acknowledgement of _____(Patient Name) receipt of the

Notice of Privacy Practices. However, I could not obtain written acknowledgement because:

□ Individual refused to sign this acknowledgement

□ Communications barrier prohibited obtaining written acknowledgement

□ An emergency situation prevented obtaining written acknowledgement

□ Other (please specify): _____

BSC Employee's Signature_____Today's Date_____

Revised 12/22/2022 zm

BSC
Brain & Spine Center
Providing Comprehensive Neurology Care

PATIENT CANCELLATION AND NO SHOW AGREEMENT

Welcome to Brain and Spine Center (BSC). We are glad you have made an appointment for yourself or

a family member.

In order to provide you with high quality health care it is important for you to keep your scheduled

appointment with the medical provider. Valuable time has been reserved for you or your family member.

A missed appointment or late cancellation of an appointment results in lost time which could have been

given to another person waiting to receive care. Every day we get many calls for appointments from both old and new patients. By canceling your appointment as soon as possible, we can help other

patients who are waiting to be seen.

Our office will try to call / text/email 10,7,4 days ahead and remind you of your appointment; however, it is your

responsibility to keep record of your appointment and to arrive on time. If you need to cancel or

reschedule your appointment please call or text 48 hours in advance.

Patients who cancel appointments with less than 24 hours' notice will be considered a No Show.

Every No Show visit will be recorded in your chart. Multiple No Show appointments within a six month

period will end your ability to make appointments and/or receive medical care at BSC.

Turn page to sign agreement

Hemant K Pandey, MD

We realize that an emergency may occur, and you may not be able to notify us. We will discuss that

situation with you when it happens.

After One (1) No Show: You will receive a letter and a phone call informing you of the No Show with a

copy of this policy/agreement. You will be able to continue to receive medical services at BSC.

After Two (2) No Shows: You will receive a discharge letter from the practice. BSC will provide

acute treatment for emergencies for up to 30 days after the letter. We cannot guarantee that you will be seen.

• New Patients who no show their initial appointment will not be rescheduled, unless there is a valid reason

Thank you for working with us to ensure that services are provided to all of our patients in the best possible way.

Acknowledgement of Cancellation & No Show Agreement

Signed: _____ Date Signed_____

Print Name: _____ Date of Birth_____

If Patient is a Minor Print Name_____ Date of Birth_____

Patient Name: _____ DOB: _____ Date: _____

Email and Text Messaging Program Consent Form

We are happy to provide our patients with the option to participate in our online patient communication system. Some of the features include the ability to:

1. Request and confirm appointments via email/text
2. Submit forms and/or documents
3. Receive text message appointment reminders
4. Submit patient satisfaction surveys
5. Text your providers directly

You may choose to discontinue your participation in our online communication system at any time simply by clicking the "unsubscribe" link found at the bottom of each email, or by replying "STOP" to a text message from us. Standard text messaging rates may apply.

Please provide BSC with the following contact information:

Home Phone: _____

Cell Phone: _____ (if you wish to receive text msg. reminders)

Email: _____

Conditions for the use of Email and Texts

Brain and Spine Center, cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Brain and Spine Center, is not liable for improper disclosure of confidential information that is not caused by Brain and Spine Center intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a) Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
b) Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c) All email will usually be filed into the client's medical record. Texts will be filed as well.
d) Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.

Continued on next page

e) Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f) Provider is not liable for breaches of confidentiality caused by the client or any third party.
g) It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

BSC uses this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this practice in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without your permission, and do not send spam.

Please sign below to indicate that you agree to allow us to use this information in providing your services.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between Brain and Spine Center and me, and consent to the conditions and instructions outlined, as well as any other instructions that Brain and Spine Center may impose to communicate with me by email or text.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Parent/Legal Guardian Signature: _____ Date: _____

BSC
Brain & Spine Center
Providing Comprehensive Neurology Care

FMLA/DISABILITY/ETC. DOCUMENTS

EFFECTIVE 04/01/17

THERE IS A $50.00 FEE FOR FMLA/DISABILITY AND ALL OTHER TYPES OF DOCUMENTS THAT REQUIRE A PHYSICIAN TO COMPLETE. THE FEE IS DUE AT THE TIME OF APPOINTMENT.

STEPS TO GETTING DOCUMENTS COMPLETED

1. SPEAK TO THE PHYSICIAN ABOUT GETTING THE DOCUMENTS COMPLETED AT YOUR APPOINTMENT. THE PROVIDER WILL THEN APPROVE AN APPOINTMENT FOR YOU TO COME BACK TO HAVE THE DOCUMENTS COMPLETED.

2. MAKE APPOINTMENT FOR COMPLETION OF THE DOCUMENTS.

3. BRING IN ORIGINAL DOCUMENTS, GIVE TO FRONT DESK TO SCAN INTO YOUR CHART SO THE PROVIDER CAN REVIEW BEFORE YOUR APPOINTMENT OR HAVE YOUR EMPLOYER OR INSURANCE FAX OVER YOUR DOCUMENTS TO 480-353-2066.

4. AT THE TIME OF YOUR APPOINTMENT THE PHYSICIAN WILL FILL OUT THE DOCUMENTS, SIGN IT AND SCAN IT INTO YOUR CHART AND THE ORIGINAL WILL BE HANDED BACK TO YOU.

5. YOUR MEDICAL ASSISTANT WILL THEN FAX A COPY TO THE FACILITY REQUESTING THE DOCUMENTS.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

Revised 7/25/18.sdm